Correspondence

The Editors will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words and must be typewritten, double-spaced, and submitted in duplicate (the original typescript and one copy). Authors will be given the opportunity to review the editing of their correspondence before publication.

Acoustic Neuromas

To THE EDITOR: I have just been rereading the otolaryngology Epitomes in the April 1989 issue and particularly the excellent review of acoustic neuromas.[1] These fascinating tumors were described to all of us in medical school, and we reflexively think of the diagnosis when encountering unilateral hearing loss.

Of course, the exquisite sensitivity of gadolinium-enhanced magnetic resonance imaging (MRI) scanning for acoustic neuromas has revolutionized the diagnosis in recent times.

I agree with Drs Jackler and Lanser. An effective and parsimonious strategy would be to first do a full audiogram with speech discrimination; then, if the result of the audiogram is characteristically abnormal, an acoustic brain-stem response (ABR) should be measured. The ABR is quite sensitive for acoustic neuroma and, if the result is abnormal, an MRI scan will make a final diagnosis in nearly every case.

What we were not told in medical school is that the acoustic neuroma is rare. In the largest population study reported to date, we found a yearly incidence of only 1 per 100,000 persons.[2] This is a fact that should be more widely recognized and appreciated, and it shows the necessity of using cost-effective diagnostic strategies such as those discussed above.

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REFERENCES

1. Jackler RK, Lanser MJ: Improved diagnosis of acoustic neuroma with auditory brain-stem evoked responses and gadolinium-enhanced MRI, *In* Epitomes—Important advances in clinical medicine—Otolaryngology/head and neck surgery. West J Med 1989; 150:452

2. Nestor JJ, Korol HW, Nutik SL, et al: The incidence of acoustic neuromas (Letter). Arch Otolaryngol Head Neck Surg 1988; 114:680

Academic Medicine

To THE EDITOR: In reference to the commentary by Dr Francesco Gallatin Beuf in the October 1989 issue, I must agree with the author that academic medicine, in my opinion, is not providing the best patient care. Most full-time physicians and surgeons associated with university hospitals are more interested in their traveling professorships or their publications, which they feel they must continue in order to maintain their full-time salaries. In days gone by, when professors at teaching hospitals had large practices of their own and were respected for the expertise in their own fields, the institution did not pay these persons. They earned their own way in return for the privilege of being a professor at a university. They taught the students, and what they taught was heavily mixed with humanitarian attitudes toward patients.

I doubt very much if, on rounds these days, one sees an academic surgeon or physician sit down by a patient's bedside, hold the patient's hand, and speak in a compassionate and caring manner, or, further yet, come back after rounds to discuss directly with the patient any particular problem or question. No, rather, these leaders of medicine and surgery are more interested in getting back to their laboratories or to their transcription of the next article or the next speech that they are preparing.

I further doubt that without a thorough overhaul of the current system, we will see the likes of Professor of Medicine, Dr Francis Wood, or Professor of Surgery, Dr Isadore Ravdin, under whom I had the privilege of studying at the University of Pennsylvania in Philadelphia at a time when there were no such things as full-time academic professorships.

I write this in the hope that it will open a dialogue and a review of the way in which we are teaching our students of medicine and surgery.

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REFERENCE

1. Beuf FG: Is academic medicine providing the best patient care?—Some personal observations. West J Med 1989; 151:477-478

Trust

To THE EDITOR: I was somewhat surprised to see a letter in the November 1989 issue by Stuart Gherini, MD,[1] castigating me for my approach to the family and child with fulminant otitis as described in my article, "A Matter of Trust," in the August 1989 issue.[2]

The policy of many medical journals is that most letters in response to articles are sent to the author(s) for comment. Is this the policy of *The Western Journal of Medicine?* [EDITOR'S NOTE: We do it frequently but not always.]

In any case, Dr Gherini is perhaps correct in one respect—Had there been an adverse outcome I might have "had a hard time justifying [my] treatment in front of a review board of [my] peers or—worse yet—a jury." That was never an issue.

The point of the piece was not to suggest a community standard of herbal treatment of acute otitis media. That was not my approach then and is not now. It was merely to describe a fascinating case of a common pediatric illness treated in an unorthodox way with good result.

Along with Dr Gherini, I, too, recall a patient of mine 18 years ago who developed chronic suppurative otitis media leading to a brain abscess and permanent sequelae. She was a Native American girl whose parents had a large family and lived in poverty on a reservation. Although the health care system, my services, and the antibiotic medications were free to them, she likely received inadequate therapy for a variety of social and economic reasons. Would Dr Gherini consider these parents noncompliant, as he obviously did the parents in my story?